

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2012  
FORM APPROVED  
OMB NO. 0938-039

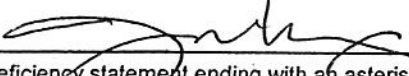
454 4/02/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445500	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  02/17/2012
NAME OF PROVIDER OR SUPPLIER  PAVILION, THE CPC			STREET ADDRESS, CITY, STATE, ZIP CODE 1406 MEDICAL CENTER DRIVE LEBANON, TN 37087		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to develop a care plan to reflect a risk for bruising related to behaviors and aspirin therapy for one (#57) of twenty-eight residents reviewed in Stage 2.</p> <p>The findings included:</p> <p>Resident #57 was admitted to the facility on March 1, 2011, with diagnoses including Dementia with Delusions, Hypothyroidism,</p>	F 279	<p>F279</p> <p>CP coordinator updated the care plan for resident #57 on 2/15/12 when error was found.</p> <p>CP coordinator and ADON will complete a review of all care plans for patients on medications that affect clotting time and ensure they are current.</p> <p>The DON will implement measures to ensure this does not recur by holding an inservice with all licensed staff on updating care plans and/or reporting new issues to the care plan coordinator</p> <p>The MDS coordinator and DON will monitor corrective actions to ensure the effectiveness of these actions, including a review of care plans to ensure updating is done as needed. This will be reviewed by the QA&amp;A Committee monthly.</p>	3/16/12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

 Administrator 2-29-12

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STREET ADDRESS, CITY, STATE, ZIP CODE

PAVILION, THE CPC

1406 MEDICAL CENTER DRIVE  
LEBANON, TN 37087

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F 279	<p>Continued From page 1</p> <p>Dissecting Aortic Aneurysm Abdominal, Long Term Use of Aspirin, Anxiety, and Depression.</p> <p>Medical record review of the physician's recapitulation orders dated February 2012 revealed "...Aspirin 81 MG (milligrams) tablet Delayed Release Oral...EVERY DAY..."</p> <p>Medical record review of the current care plan revealed the resident was at high risk of bruising related to episodes of behaviors and long term use of aspirin therapy.</p> <p>Observation on February 14, 2012, in resident #57's room at 9:21 a.m., revealed a dark purple bruise on the resident's right hand.</p> <p>Observation on February 15, 2012, in resident #57's room at 9:10 a.m., revealed a small dark purple bruise to the left hand. Continued observation revealed resident #57 pinched the skin on the left hand and said, "This happens all the time. I try to rub it off but it stays on there."</p> <p>Interview in the conference room on February 15, 2012, at 8:35 a.m., with the Assistant Director of Nursing (ADON) revealed "(Resident #57) will hit &amp; slap at times during direct care. Sometimes if you just touch lightly on the hand or arm to direct (resident) will pull away and (resident)'s skin is very fragile. (Resident) bruises easy. I didn't see anything recorded about the bruise on (resident)'s hand. When noticed nursing should document in the progress notes."</p> <p>Interview on February 15, 2012, at 10:45 a.m., Licensed Practical Nurse #1 reviewed the current care plan and stated, "I don't have (resident)'s</p>	F 279		

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F 279	Continued From page 2	F 279		
F 309	care planned for bruising and (resident) is on aspirin. I need to add that to the care plan."	F 309	F309	3/17/12
SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING			
	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.		The DON will implement corrective actions for residents #76 affected by this practice by identifying the nurses involved and providing retraining to each of them on the policy for sliding scale insulin.	
	This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to follow physician's orders for sliding scale insulin for one (#76) of ten sampled residents reviewed in Stage 2.		The ADON will assess residents having the potential to be affected by this practice and will check 2-3 times weekly that correct dosages are being provided by completing audits of the eMAR.	
	The findings included:		The DON will implement measures to ensure this does not recur by holding an inservice with all licensed staff on sliding scale insulin procedures.	
	Resident #76 was admitted to the facility on January 15, 2011, with diagnoses including Diabetes Type II, Congestive Heart failure, Chronic Obstructive Asthma, Atrial Fibrillation, Hypertension, and Hyperlipidemia.		The DON and/or her representative will monitor corrective actions to ensure the effectiveness of these actions, through audit of all patients that receive sliding scale insulin. This will be reviewed by the QA&A Committee monthly.	
	Medical record review of the physician's order dated October 9, 2011, revealed "...NovoLIN R...100 UNIT/ML Solution Subcutaneous - FOUR TIMES DAILY Everyday: ACCU (accucheck) checks Q (every) AC (before meals) and Q HS (at bedtime) 0-200=0 units,201-250=2 units,251-300=4 units,301-350=6 units,351-400=8 units, 401-450=10 units,notify			

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F 309	<p>Continued From page 3</p> <p>MD (medical doctor) for BS (blood sugar) &lt;60 or &gt;450..."</p> <p>Review of the electronic Medication Administration Record (eMAR) dated January 2012, for resident #76 revealed the residents's blood sugar level on January 22, 2012, at 6:45 a.m., was 180 mg/dl [milligrams per deciliter]. The documented amount of NovoLIN R insulin administered was 2 units. The physician's ordered amount for a blood sugar level of 180mg/dl was 0 units.</p> <p>Medical record review of Resident #76's eMAR dated February 2012, revealed the resident's blood sugar level on February 12, 2012, at 4:45 p.m., was 300mg/dl. The documented amount of NovoLIN R insulin administered was 6 units. The physician's ordered amount for a blood sugar level of 300mg/dl was 4 units.</p> <p>Review of the facility's "Insulin Administration" policy documented, "Purpose To administer guidelines for the safe administration of insulin to residents with diabetes...8. Check the order for the amount of insulin...12. Double check the order for the amount of insulin...15. Re-check that the amount of insulin drawn into the syringe matches the amount of insulin ordered..."</p> <p>Interview and medical record review at the 100/200 hall nurse's station on February 15, 2012, at 10:45 a.m., with Licensed Practical Nurse (LPN) #1 revealed the NovoLIN R Sliding Scale Insulin [SSI] administered to resident #76 on January 22, 2012, was 2 units, and confirmed the resident recieved 2 units of insulin." When asked if this was the dose ordered by the</p>	F 309		

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F 309	Continued From page 4 physician LPN #1 stated, "Should not have been given any insulin for 180." LPN #1 reviewed the NovoLIN R SSI administered to the resident on February 8, 2012, was 6 units and should have been 4 units, resulting in a medication error.	F 309			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to administer medications without error for three of fifty one opportunities, resulting in a 5.76% medication administration error rate.  The findings included:  Resident #75 was admitted to the facility on June 17, 2011, with diagnoses including Presenile Dementia with Depressive Features, Vascular Complications of other Vessels, and Palpitations.  Medical record review of the February 2012, recapitulation physician's orders revealed a physician's order dated June 17, 2011, "...Aricept (Donepezil Hydrochloride) 10 MG Tablet Oral (By mouth)- BEDTIME Everyday: 1 tablet p.o. (by mouth) QHS (every bedtime)...Aspirin EC (Aspirin) {enteric coated dissolves in the intestine vs the stomach} 81 MG Tablet Delayed Release Oral (by mouth) - BEDTIME Everyday: 1 tablet p.o. QHS..."	F 332	F332  The LPN contacted the physician on 2/14/12 and received orders to change the medication for resident #75 to the way it was currently being provided. The DON will implement corrective actions for residents #22 affected by this practice by identifying the nurse involved and providing retraining on the technique for eye drop application.  The DON and her representatives will complete an audit on all physician orders and the times that are placed on the eMAR to ensure medications are delivered as ordered.  The DON will implement measures to ensure this does not recur by holding an inservice with all licensed staff on proper med pass techniques  The DON and/or her representative will monitor corrective actions to ensure the effectiveness of these actions, by completing med pass audits and by having the pharmacist complete med pass audits. This will be reviewed by the QA&A Committee monthly.	3/17/12	

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F 332	<p>Continued From page 5</p> <p>Observation on February 14, 2012, at 4:35 p.m., near the 100/200 desk, revealed Registered Nurse (RN) #1 prepared resident #75's 5:00 p.m., medication. Observation revealed RN #1 crushed 1 Enteric Coated Aspirin 81 mg, and 1 tablet Aricept 10 mg, and administered the medications to resident #75 in the resident's room.</p> <p>Review of the physician's orders and interview with RN #1 on February 14, 2012, at 5:00 p.m., at the medication cart, near the 100/200 nurse's desk, confirmed the Enteric Coated Aspirin was crushed and Enteric Coated medications should not be crushed, the Enteric Coated Aspirin and the Aricept were ordered to be administered at bedtime and were administered at 4:35 p.m., (before supper) and not at bedtime as ordered by the physician.</p> <p>Resident # 22 was admitted to the facility on April 1, 2011, with diagnoses including Senile Dementia, Cellulitis, Hypertension, Diabetes Type II, Cataract in Degenerative Ocular Disorder, and Iron Deficiency Anemia.</p> <p>Medical record review of the physician's recapitulation orders for February 2012, revealed "...Patanol...0.1% Solution Ophthalmic - TWICE A DAY Everyday one drop to each eye twice daily..."</p> <p>Observations in resident #22's room on February 15, 2012, at 10:37 a.m., revealed Licensed Practical Nurse (LPN) # 1 administered one drop of Patanol into resident #22's right eye, administered oral medications, and administered one drop of Patanol into the left eye and stated,</p>	F 332		

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F 332	Continued From page 6 "Let me do that again...". LPN #1 then administered a second drop of Patanol into the left eye. and administered two drops of Patanol into the left eye. .  Interview in the hallway outside room 104 on February 15, 2012, at 10:50 a.m., LPN #1 was asked how many drops of Patanol was administered. LPN #1 stated, "I didn't see the first drop drop down. That's why I did it again" resulting in a medication error.	F 332			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on facility policy review, observation, and interview, the facility failed to ensure food was prepared under sanitary conditions as evidenced by improper food holding temperatures.  The findings included:  Review of the facility's "FOOD STORAGE" policy documented, "...8. Hot foods or potentially hazardous food will leave the kitchen or steam table at 140 (symbol for degrees) or above..."	F 371	F 371  Food was reheated to proper temperature immediately.  Tray preparation was halted due to the improper temperatures. After the food was reheated, the temperatures were 164 degrees F for the chicken and 157.6 degrees for the pork chops. Tray preparation continued after desired temperatures were present.  An inservice was held by the Dietary Supervisor for all dietary staff on the FOOD STORAGE policy, including proper food temperatures to serve hot foods, and new temperature logs on 2/21/12  Daily Temperature Logs have been adjusted to include space for temperatures to be recorded before tray preparation begins and before the last tray cart is prepared. These forms are reviewed by the Dietary Supervisor.	2/21/12	

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F 371	Continued From page 7  Observations in the kitchen on February 15, 2012, at 12:00 p.m., revealed: a. chicken 139.2 degrees Fahrenheit (F). b. pork chops 130 degrees F c. pureed macaroni and cheese 133.8 degrees F. The food was rechecked with another thermometer by the staff revealed: a. chicken 135 degrees F b. pork chops 135 degrees F. The temperature of the chicken after being placed in the steamer was 138.8 F. Sixteen employee trays and twenty resident trays had been served with food at the wrong temperature.  The staff then placed the chicken on top of the stove to heat. The temperature of the chicken when rechecked after heating was 164 degrees F. The temperature of the pork chops after reheating was 157.6 degrees F.  During an interview in the kitchen on February 15, 2012, at 12:10 p.m., dietary server #1 was asked when temperature of the food is checked. Dietary server #1 stated, "just before serving". Dietary server #1 was then asked if the temperature was rechecked if a resident complained of cold food. Dietary server #1 stated, "No, I would turn up my steam table...I might fix them another plate of food..." Dietary server #1 was asked if the food temperature would ever be rechecked. Dietary server #1 stated, "...no I would just turn the table up if I thought the food was cold..." The Dietary Supervisor replied, "...You must have uncovered the steam table too soon..."	F 371			
F 514	483.75(I)(1) RES	F 514			

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F 514 SS=D	<p>Continued From page 8</p> <p><b>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</b></p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide accurate physician's orders for one (#75) of twenty eight residents reviewed in stage two.</p> <p>The findings included:</p> <p>Resident #75 was admitted to the facility on June 17, 2011, with diagnoses including Presenile Dementia with Depressive Features, Vascular Complications of other Vessels, and Palpitations.</p> <p>Medical record review of resident #75's physician orders dated from June 17, 2011, to February 14, 2012, revealed "...Aricept (Donepezil Hydrochloride) 10 MG Tablet Oral (By mouth) - BEDTIME Everyday: 1 tablet p.o. (by mouth) QHS (every bedtime)...Aspirin EC (Aspirin) {enteric coated dissolves in the intestine vs the</p>	F 514	<p>F514</p> <p>The LPN contacted the physician on 2/14/12 and received orders to change the medication for resident #75 to the way it was currently being provided.</p> <p>The DON and her representatives will complete an audit on all physician orders and the times that are placed on the eMAR to ensure medications are delivered as ordered.</p> <p>The DON will implement measures to ensure this does not recur by holding an inservice with all licensed staff on verifying physician orders on both the order sheet and eMAR.</p> <p>The DON and/or her representative will monitor corrective actions to ensure the effectiveness of these actions, by completing audits of physician orders and eMAR documentation. This will be reviewed by the QA&amp;A Committee monthly.</p>	3/17/12

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F 514	<p>Continued From page 9</p> <p>stomach} 81 MG Tablet Delayed Release Oral (by mouth) - BEDTIME Everyday: 1 tablet p.o. QHS..." Continued review revealed various nurse's signatures that the physician's orders were reviewed each month and found to be accurate.</p> <p>Observation on February 14, 2012, at 4:35 p.m., near the 100/200 desk, Licensed Practical Nurse (LPN) #1 prepared resident #75's medication. Observation revealed LPN #1 crushed 1 Enteric Coated Aspirin 81 mg, and 1 tablet Aricept 10 mg. Continued observation revealed LPN #1 administered the medications to resident #75 in the resident's room.</p> <p>Review of the physician's orders, and interview with LPN #1 on February 14, 2012, at 5:00 p.m., at the medication cart, near the 100/200 nurse's desk, confirmed the Enteric Coated Aspirin had been crushed daily, and administered with the 5:00 p.m., medication pass for several months. Continued review and interview, revealed the Aricept was ordered to be administered at bedtime and was administered with the 5:00 p.m., medication administration. Continued interview revealed the physician orders were reviewed monthly by a nurse and signed as accurate.</p>	F 514		

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